FAQ for 834 v 4010

Q. Can plans make network providers move to standard transactions before 10/16/03?

A. This is a business decision between the plan and its provider network. HIPAA regulations do not preclude plans from requiring that their providers use standard transactions in advance of the compliance deadline, but HIPAA non-compliance penalties would not apply to a provider that has submitted a plan until 2003.

Q. Must every employer/plan sponsor independently submit an ASCA compliance plan to obtain the extension? Our company is a third party administrator (TPA) for a large number of employer-sponsored health plans under ERISA. They all have the same implementation plan. May we file one plan as a TPA for all these plans?

A. First, determine whether the plans are "small health plans" for purposes of HIPAA. If they are, they already have a compliance date of October 16, 2003, and are not eligible to file for a further extension. Many ERISA plans will meet this definition. For those plans that are not "small health plans," the obligation to file a compliance plan rests with the plan, not the TPA. The use of the same TPA does not make two or more plans "related entities." However, the TPA may submit the ASCA compliance extension plans on behalf of the employer/sponsor.

Q. With regard to reinsurance; Is it necessary for a SFGHP (self funded group health plan) to have BAA with the stop-loss carrier (reinsurance) as this is part of operations?

A. Nearly all of the things that business associates may do for covered entities will come under the heading of health care operations. In all of these cases, a BA contract is required in order for the CE to disclose PHI to the BA, or permit the BA to create or collect PHI on the CE's behalf. Reinsurance is no exception.

Q. What reasoning was behind the decision to impose the 10,000-member limit?

A. Page 43 of the implementation guide; Loop 2000 INS contains the following notes:

1. Subscriber information must precede dependent information in a transmission, or the subscriber information must have been submitted to the receiver in a previous transmission.

2. No more than 10,000 INS segments can occur in a single 834 transaction. Multiple transactions within a single interchange can be used to transfer information on larger numbers of members.

Note 2 was the bases of the decision to impose the 10,000 member limit.

Q. RECIP_SEX-CODE: Will the State of Michigan be sending a value of 'U'Unknown)? DMG03_2100A = 'U'?

A. The State of Michigan has modified their system to accommodate the possibility of transmitting "U" Unknown in DMG03_2100A, when the gender is not available in the system.

Q. RECIP_PROG_CODE: Will the State of Michigan continue to support the submission of this information on the 834 transaction?

A. The State of Michigan has developed a policy number used to identify the coverage of a recipient. The Policy Number, which will be transmitted in Loop 2300 of the Health Coverage Policy Number segment, consists of:

Scope
Coverage
Level of Care
Program Code

Q. It is our understanding that we will continue to receive the 834 equivalents of the Card Cut-Off (3653), First of the Month (3653S) and Weekly (4684) enrollment files. How can each 834 be recognized, as it's proprietary file equivalent?

A. MDCH will post all EDI Transactions to the corresponding service bureau mailbox. 834 Card Cut-Off, First of the Month and Weekly files will be distinguished by their file name:

Card Cut-Off	ID: 4976(T/P)
First of the Month	ID: 5012(T/P)
Weekly	ID: 5013(T/P)

File names will be followed by a "T" when testing and a "P" when in production.

Q. PROVIDER-ID: Michigan's guide doesn't show support for any NM1 loops for provider information. How will MDCH be reporting the provider number that is currently entered in bytes 3-9 of the 3653 files?

A. The data clarification document shows that Provider-ID will be transmitted as the members group number. This will be transmitted in Loop 2000 (Member Level Detail)

Segment REF (Member Policy Number)
Element REF02 (Reference Identification).

Q. Regarding the RECIP-OI-CODE: When is Appendix B going to be available?

A. Apendix B is currently available.

Q. Please clarify what fields on the 834 will represent the following substatus.

1 - Authorized Begin Date (Current Enrollees)
2 – Authorized Begin Date (new enrollees)

3 – Negative action date (pending negative action)
4 – Eligibility End Date (eligibility end date)
5 – Effective End date (Disenrolled)

A. The table below illustrates the relationship between substatus codes and 834 dates.

Receipeint Substatus	Loop 2000		Loop 2300	
	Member Level Dates		Health Coverage Dates	
	DTP01: Date/Time Qualifier	DTP03: Date/Time Period	DTP01: Date/Time Qualifier	DTP03: Date/Time Period
1 continuing enrollee			348	AUTHO-BEGIN-DATE
2 new enrollee	356	AUTHO-BEGIN-DATE	348	AUTHO-BEGIN-DATE
3a pending negative action, enrolled	474	Last day of current month	348	AUTHO-BEGIN-DATE
3b pending negative action, new enroll	356 474	AUTHO-BEGIN-DATE Last day of current month	348	AUTHO-BEGIN-DATE
4 disenrolled - lost Medicaid eligibility			349	"Last day of current month"
5 disenrolled			349	AUTHO-END-DATE